PRINTED: 11/27/2007

		I AND HUMAN SERVICES  E& MEDICAI <u>D SERVICES</u>					M APPROVEI O. 0938-039 <sup>-</sup>
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUC	CTION	(X3) DATE	
		09G119	B. WIN	à		11	/16/2007
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS 4515 EDSON PI			<u></u>
IDI				WASHINGTO	. 1 (		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	VIDER'S PLAN OF CORRECTIVE ACT REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{W 000}	A follow-up survey November 14, 2007 to determine the far previous condition I October 5, 2007. Crandomly selected sampled in October added to the sample In addition, focused follow-up to the Oct follows:  - Client #1's mealtir repositioning and are Client #3's active that and adaptive equipations of this observations, interval diministrative staff program serving the review of record and administrative of determined that the compliance with all participation; however	was conducted from 7 through November 16, 2007, cility's compliance with evel deficiencies cited on Clients #2 and #5 were from the five clients originally r. Clients #6 and #7 were then e. I reviews were conducted in cober 5, 2007 survey, as me protocol, nutritional intake, daptive equipment needs; treatment, physical therapy	{W 00	00}		2001 DEC 20 P 2: 29	RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION
{W 104}	follows. 483.410(a)(1) GOV	·	{W 10	4) W104	-   -   -   -   -   -   -   -   -   -		
		must exercise general policy, ng direction over the facility.					
	This STANDARD is	s not met as evidenced by:			•		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 asys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/27/2007 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		09G119	B. WING		11/16/2007
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO 4515 EDSON PLACE, NE WASHINGTON, DC 20019	DE .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
{W 104}	governing body faile implementation of it equipment: acquisit and repair, for two of the facility. (Clients  The findings include  1. Cross-refer to W Qualified Mental Re November 14, 2007 revealed the agency for timely acquisition and repair of adaptive equipment shall occupied the adaptive equipment shall occupied at from when the there are circumstar provider and or DDS this timeline, such a approvals, every effective to the stimeline, such a approvals.	eview and record review, the ed to ensure timely to policy on adaptive tion, replacement, modification of the eight clients residing in #1 and #3)  e:  /436. Interview with the etardation Professional on //, at approximately 3:00 PM, y had established guidelines in, replacement, modification we equipment. According to ment policy: "acquisition, or replacement of adaptive cur within sixty days of the need was determined. While need was determined. While need was determined with s delays in insurance out should be made to meet or and to follow-up with the	{W 104	This Standard will evidenced by:  (1) Cross reference to WH36.	be metas response 12.19.07 ongoing
	governing body activimplementation of the	nce, however, that the vely monitored the his policy to ensure timely ement of wheelchairs for			
	evidence that the go the clients' adaptive	ped.	W 111	(2) Cross reference to W159.2	response 12.14.07

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

P.6

(X5) COMPLETION DATE

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 11/27/2007

CENTERS FOR MEDICARE		:	FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	09G119	B. WING	11/16/2007

ID

**PREFIX** TAG

NAME OF PROVIDER OR SUPPLIER

LQI

(X4) ID PREFIX TAG

STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE

WASHINGTON, DC 20019

W 111	Continued From page 2	10/ 444				1
VV 111	Continued From page 2	W 111	WIII :			
	The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.					
	This STANDARD is not met as evidenced by: Based on interview and record review, facility nurses failed to update client records as indicated, for one of the six clients in the sample. (Client #4)		This Star as evider	idard w noed by:	ill be met	
1	The findings include:		1 -			
	1. Nursing supervisors failed to provide oversight to ensure accuracy of client records, as evidenced by the following:  On November 15, 2007, at approximately 12:30 PM, review of Client #4's Nursing Progress Notes revealed that on November 10, 2007, 8:30 AM, a nurse wrote the following: "slight pink area on right hand. No pain noted. Area cleaned with normal salinePCP made aware." Subsequent review of the Staff Daily Progress Notes in Client #4's record revealed nothing unusual was documented on November 9, 2007. There was no daily progress note from a direct support staff for the morning of Saturday, November 10, 2007. At 1:08 PM, the "day nurse" was asked about the nurse's progress note and she stated that she was previously unaware of any "pink areas" discovered on Client #4. She did, however, state that the client had receive a flu shot on November 9, 2007.		LPN staff wi	Il receive needed It docum Ition is a the act	to further entation	12·18·07 ongoing
	Initially, this was being treated as if it were an injury of unknown origin. However, telephone	- · ·	• • • •		-	
M CMS-256	67(02-99) Previous Versions Obsolete Event ID: DWO41	2 Fac	ility ID: 09G119	1	f continuation sheet	Page 3 of 22

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

MULTIPLE CONSTRUCTION

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G119	B. WING _		11/16/2007	
NAME OF F	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP 1515 EDSON PLACE, NE WASHINGTON, DC 20019	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ÓN SHOULD BE COMPLÉTION HE APPROPRIATE DATE	N
W 111	at 1:16 PM, reveal seen the pink area shoulder," in the loreceived a flu shot that he had not be received a flu shot shot, however, had same Nursing Programmers indicated that hand" instead of in common error in common error in common error the telephone that too far apart to get Client #4's medical that supervisory nurse should be seen that the seen that the seen that the seen that supervisory nurse should be seen that supervisory should be seen that supervisory should be seen that	age 3  PN who had made the entry, ed that the nurse had indeed on the "upper arm, near the acation where the client had Further interview revealed en aware that the client had on the day before. The fluid been documented in the gress Notes, on November 9, entioned interviews, the day at the error of writing "right dicating the upper arm was a certain immigrant populations. Stor of Nursing had stated over the hand and upper arm "are confused." Further review of I chart failed to show evidence arsing staff had reviewed Client is to ensure accuracy.	W 111	WIII, Continued.		
	#4's HMCP, to reflephysical therapy protreatment for pain.  a. On November 1 Health Managemer September 24, 200 due to DJD;" though for degenerative join indicated that staff range of motion (Refor signs of pain. Hupdated Individual Cottober 5, 2007, retherapist and interdirect.	led to update/ revise Client ect a change in the client's ograms and/or prescribed  5, 2007, review of Client #4's ent Care Plan (HMCP), dated electrical for pain h not spelled out, DJD stands int disease. The HMCP were to provide the client OM) exercises and to monitor lowever, review of the client's Support Plan (ISP), dated evealed that his physical isciplinary team had changed the client now was to ambulate		(2) Reference resignation (2) Reference resignation (2) Omep will review program objects. Physical Therapis change or mod recommended.  Client # 45 HNCP upd alod as need reflect change.	and duscuss e with the f and/ ifx as	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OCITIE!	<u> </u>	. 4 (112213) 112 321 111 323			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATÉ SURVEY COMPLETED
		09G119	B. WING		R 11/16/2007
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIF	, CODE
I D I				4515 EDSON PLACE, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION DATE
W 111	Continued From pa	ge 4	W 111	WIII, continued.	
	around the home a with staff instead of	ind dance for up to 3 minutes the ROM exercises. The nupdated to reflect the new		<b>77</b> , (1)	
	h In addition the F	HMCP failed to reflect the use		(b) Reference m WIII #1 and	2501780 78
	of medication for tre #4's physician's ord included a handwrit 2007 for Tylenol 32 needed for pain or t degrees. On Octobe evaluated in a hosp and swelling of his	eatment of joint pain. Client lers (POs) dated June 1, 2007 ten notation dated May 1, 5 mg x 2 tabs was ordered as temperature greater than 100 ler 2, 2007, the client was ital ER after experiencing painingth thigh and foot. The ER of listed as primary diagnosis		WIII #1 and  (3) Cross-referent  to W1252,	
	"arthritis - degeneral physician's SOAP in not reflect Tylenol for note dated October for joint pain." The failed to specify the administration of the physician's orders is pharmacy, dated Sereflect Tylenol. Fur medical record faile October 13, 2007 S of Tylenol on an as	tive." The primary care tote dated October 4, 2007 did or pain; however, his SOAP 13, 2007 included "P: Tylenol October 13, 2007 SOAP note frequency/ parameters for a Tylenol. The most recent esued/ printed by the eptember 1, 2007, did not ther review of the client's d to clarify whether the OAP note was a continuation needed (PRN) basis or tied a change to daily/ routine			
{W 120}	observed behaviora and #4's records, in programs.	252. Staff failed to enter I incident data into Client #1's accordance with behavior /ICES PROVIDED WITH	(W 120)	`   ·	
	The facility must as:	sure that outside services-			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S	
	. !	09G119	B. WING		!	R 1 <b>6/2007</b>
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
(W 120)	Continued From pa		{VV 120	0) W120, Continued		
	Based on observation review, the facility face each client's day proprograms provided interdisciplinary teal	s not met as evidenced by: on, interview, and record ailed to effectively monitor ogram to ensure that the day services in accordance with m recommendations, for three the sample. (Clients #2, #5		This Standard Will as evidenced by	be met	
	were observed at the 10:36 AM. Although Retardation Profess documented a visit (	to this day program on ontinued deficiencies were				
	Client #5 was obsercafeteria. She was to a dining table with little to no staff interaengaged in a meaning 70-minute period. Three direct support more than 15 other of her Active Treatm "personal care, impleactivity of choice, reparation, choice and 11:00 AM - 11:30 AM between 11:30 AM -	until approximately 11:50 AM, ved seated in the lunch room/seated in her wheelchair, next in no materials presented and action. She was not observed ingful activity throughout the there were approximately staff in the cafeteria with clients. At 11:28 AM, review the schedule revealed ementation of ADL objectives, positioning between 9:30 AM medule then listed "lunch activities, personal care" from M, and she was to have lunch 1:30 PM. Observations id not receive continuous		(1) omer will address of with the day progra and develop addition strategies as needed active treatment avactivities and address they arise.	im statt ional ad	12.14.07 ongoing

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTE	NO FOR MEDICARE	& MEDICAID SELVICES		<u></u>	CIVID IVO. 0900-059 (
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .	ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED
		09G119	B. WIN	/G	11/16/2007
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	<del></del>
15.				4515 EDSON PLACE, NE	7
IDI				WASHINGTON, DC 20019	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE COMPLETION THE APPROPRIATE DATE
{W 120}	,	~	{W 13	<sup>20}</sup> W120	
	2. At approximately coordinator was obe holding Client #5's again observed wal area" of the cafeteriat approximately 11 period, or while Clie - 12:05 PM), was the plate, in accordance protocol.  3. At 11:01 AM, dire program stated that and no staff assistaminutes later, intervindicated that she at AM, Client #5 was cassistance. At approday in the residence described a technique Client #5 to eat mor some of her food to her plate so that while food ends up on the instead of heaping") same technique dur 4:00 PM. She state staff could intervene At 4:33, the QMRP anot yet shared the inprogram. During dir PM, direct support selient to scoop foods	the morning of November 14,  11:02 AM, the day program served walking in the cafeteria high sided plate. He was king to and from the "serving ia holding her high sided plate, 35 AM. At no time during this int #5 ate her lunch (11:52 AM here a plate guard attached to ance with her mealtime.  The continue was needed. A few liew with the coordinator also the independently. At 11:52 abserved eating without staff is spooning her food rapidly ff did not provide her any oximately 2:50 PM later that the Director of Nursing ue by which staff encourage e slowly. They also push wards the back and side of en she scoops her food, less spoon ("a 1/2 a teaspoon. The QMRP described the ling an interview that started at differential that this was the only way without upsetting the client. The acknowledged that she had aformation with the day oner, at approximately 5:25 taff in the home allowed the swithout assistance (it was alls heaping). They then		Documentation with the client record  2. Reference responded.  3. and will follow day program and additional train related.  Also, reference to U120, #1.	onse to  up with  nd provide  ling as

PRINTED: 11/27/2007

		AND HUMAN SERVICES				APPROVEC 0938-0391
STATEMENT	CS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SI	URVEY
		09G119	B. WING			R <b>6/2007</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 4515 EDSON PLACE, NE WASHINGTON, DC 20019	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{W 120}	the side and back of better controlled, as 4. At 12:23 PM, Cli coordinator retrieved dated June 1, 2007 held protocols for a The protocol had be program nutritionist was leaving the day coordinator present dated October 15, 2 retrieved from a file Interview with the Obrought the protocol October 23, 2007, von the protocol by date. Comparison of differences, as follo 15, 2007 protocol we Program to bring the hand-over-hand assignationally protocol; and (c) the reflect "Do not give the October 15, 200 evidence that day protocol in the protocol of the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protocol in the reflect "Do not give the October 15, 200 evidence that day protoco	echnique of pushing foods to if plate; the client's pace was a intended.  ent #2's day program dher mealtime protocol, from the cafeteria binder that ill clients in Client #2's group. The developed by the day.  However, while this surveyor program, at 12:49 PM, the red another mealtime protocol, 2007, which he said he had in the nurse's office.  MRP revealed that she had in the day program on which was also documented ay program staff initials with of the two protocols revealed ws: (a) added to the October as a reminder to "See e cup to her mouth with sistance;" (b) the June 1, 2007 ext the "1 cup of milk, 1 cup of unch and "1 cup of water" at a ted on the October 15, 2007 ext and 1, 2007 protocol did not raisin bread" as indicated on 107 protocol. There was no rogram staff were exised protocol.		(4) Reference responsibility of the will solve address position and adaptive expensive will also results with the to veriby that are implementing accordance to	nse to  -up with taff and oning jupment	12-14-07 ongoing
		ayed in her wheelchair all				

day. She replied no, she was repositioned onto mats either during the morning hours or in the afternoon. She further indicated that another class was using the mats at that time; therefore, Client #2 would be repositioned after lunch. At

	. ,	I AND HUMAN SERVICES	<del></del> 1		,	FORM	: 11/27/200   APPROVEI   0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	JLTIPLE CONSTRUCT	DN	(X3) DATE S COMPLI	
		09G119	B. WIN	G	<u>                                     </u>	l	6/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI 4515 EDSON PLAC WASHINGTON, I	E, NE	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CÓ	ER'S PLAN OF CO RRECTIVE ACTIO RENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
(W 120)	approximately 12:2 Reposition Chart for that she was reposentry for November the morning and inschart indicated "who documented. At 12 asked about Client that he personally rouring the afternoowas not documention November 15, 2 stated that she had	ige 8 5 PM, review of the client's or November 2007 revealed itioned once per day. Each indicated that it occurred in stead of being on mats, the eelchair tilted" for each day 2:30 PM, the coordinator was #2's repositioning. He stated epositioned her to a mat ins. He acknowledged that he ing the afternoon repositioning. 2007, at 10:25 AM, the QMRP intercurate and had not	{W 12	(0)			

It should be noted that interviews with the QMRP on November 14, 2007, at 9:37 AM and November 15, 2007, at 10:25 AM, revealed that she had not observed either Clients #2 or #5 receiving their lunch meals during her October 23, 2007 visit. She acknowledged that she had not returned to the day program since then to verify that staff were properly implementing their mealtime protocols, including use of adaptive equipment.

observed Client #2 being repositioned at the day program. She acknowledged that she had not verified that the client was repositioned at least every two hours, in accordance with her annual

It should be further noted that during the November 15, 2007, interview, at 10:25 AM, the QMRP acknowledged that she had not sought documentation from the day program or otherwise tried to verify through observation that day program staff were repositioning the five clients at least every two hours, in accordance with their plans.

FORM CMS-2567(02-99) Previous Versions Obsolete

plan, dated June 22, 2007.

Event ID: DWO412

Facility ID: 09G119

if continuation sheet Page 9 of 22

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SI COMPLE	
		09G119	B. WING _				R <b>6/2007</b>
NAME OF F	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP 515 EDSON PLACE, NE VASHINGTON, DC 20019	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOU HE APPRO	JLO BE	(X5) COMPLETION DATE
{W 124}	RIGHTS  The facility must en Therefore the facilit parent (if the client of the client's medic and behavioral stat	Sure the rights of all clients.  y must inform each client, is a minor), or legal guardian, cal condition, developmental us, attendant risks of e right to refuse treatment.	{W 124}	W124, Continued			
	Surveyor: Dugger, O Based on observativerification, the facileach client or their for the client's medicand behavioral statutreatment, and the rone of the four client. The finding includes. The October 5, 200 revealed that the facility reviewed Client #4's with his legal guardithe use of restrictive behaviors. On Nove approximately 2:45 Retardation Profess Client #4's court-approximately 2:45 retardation Profess Profess Profess Profess Profess Pr	on, interview and record lity failed to ensure the right of egal guardian to be informed all condition, developmental us, attendant risks of light to refuse treatment for its in the sample. (Client #4) is:  7 recertification survey had cility failed to document having a Behavior Support Plan (BSP) an. The BSP incorporated a techniques to manage his ember 14, 2007, at PM, the Qualified Mental ional (QMRP) stated that cointed guardian had not sciplinary team annual ISP 5, 2007, which was verified ndance sheet. The QMRP he had not telephoned or ct with the legal guardian		This Standard will as evidenced by:  Beforence responsible to discuss chere behavior supportant use of restrict risks/benifits and refuse treatment	use to use to not # of Pla uve to right	o WIII  wordian  4's  an  chalges	12.20.07 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUIL		COMPLET	red
		09G119	B. WING	3	11/16	/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4515 EDSON PLACE, NE WASHINGTON, DC 20019	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	.(XS) COMPLETION DATE
(W 124)	2007, at approximathe QMRP and nurse review of the client's records, revealed comprehensive joint 483.430(a) QUALIFRETARDATION PER Each client's active integrated, coordinated qualified mental retained assed on observation review, the facility's Professional (QMRI monitor, integrate a active treatment professional p	1.2-3. On November 15, tely 3:20 PM, interviews with sing staff, in conjunction with a s medical and active treatment hanges in his willingness to all therapy programs/as no evidence of a t evaluation in the record.	{W 12	9) W159 This Standard will as evidenced by:	l be met	
	monitor to ensure the implemented clients updated on October 2. The QMRP failed sheets were used a #3, #7 and #2.  a. Client #3 was obs	120. The QMRP failed to hat day programs 'mealtime protocols, as 15, 2007. It to ensure that transfers recommended for Clients		(2) amply ordered transfer for #3, #7 and #  (3) amply will provide ad staff training as no	rsheets 2,	12.20.07 ongoing
٠.	wheelchair on Nove	served seated in his mber 14, 2007 at 8:52 AM. #3's physical therapy (PT)		(3) amplifyill provide ad staff training as no conduct routine o	ditional seded and bservations	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION  LDING	COMPLE	
-		09G119	B. WIN	G		6/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 4515 EDSON PLACE, NE WASHINGTON, DC 20019	0005	, <i>'</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY:FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{W 124}	Cross-refer to W33 2007, at approximathe QMRP and nurreview of the client records, revealed oparticipate in physicactivities. There was comprehensive joint 483.430(a) QUALITETARDATION Pleach client's active integrated, coordin	B1.2-3. On November 15, ately 3:20 PM, interviews with sing staff, in conjunction with a sing staff, in conjunction with a simple standard active treatment changes in his willing tess to call the rapy programs/ as no evidence of a not evaluation in the record.	{W 12	This Standard with as evidenced by	Il be met	
•	Based on observative review, the facility's Professional (QMR monitor, integrate a active treatment proclients in the sample #7)  The findings included the findings included the consument of th	V120. The QMRP failed to hat day programs s' mealtime protocols, as		(1) Cross reference res W120 (2) QMPP ordered trans- for #3,#7 and		12.20.07 ongoing
: :	#3, #7 and #2.  a. Client #3 was ob wheelchair on Nove	served seated in his ember 14, 2007 at 8:52 AM." t #3's physical therapy (PT)		(3) ampf will provide a staff training as conduct routine	additional needed and	,

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVE COMPLETED	Y
		09G119	B, WING		11/16/20	07
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP GO: 4515 EDSON PLACE, NE WASHINGTON, DC 20019	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY-FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) MPLETION DATE
{W 159}	assessment, dated 16, 2007 at 2:37 PM recommended. Into and observation on revealed the transfe bedroom. Interview indicated that the trunderneath the clie wheelchair. The cli home from his day November 16, 2007 his wheelchair.  b. On November 14 was observed seater review of her PT as 2007, revealed a retransfer sling. Observed of the transfer sling. Observed transfer on November 2:50 PM revealed the client's bedroom. In PM revealed the trafficulties bedroom are had some difficulty records indicated we process. On Novem QMRP confirmed the difficulties in transfer indicated that Client partuicipating in the degree. At 7:02 PM assessment, dated recommendation to	April 24, 2007, on November of revealed a transfer sling was serview with direct case staff. November 16, 2007 3:00 PM serisling was in the client 's with the QMRP at 3:15 PM ansfer sling should be placed intimen he is in his ent was observed returning program at 3:40 PM on without his transfer sling in without his transfer sling in without his transfer sling in examined at the part with 15, 2007 at 8:20 AM Client #7 and in her wheelchair. The sessment, dated June 16, commendation to purchase a creation and interview with 15, 2007 at approximately neitransfer sling was in the terview with the QMRP at 2:55 insfer sling should stay with proper lifting.  4, 2007, at 6:43 PM, the ad nursing assistant were g Client #2 from her cliner in the living room. They getting the client, whose as obese, through the noter 15, 2007, at 6:50 PM, the last there had been some	(W 15	9) W159, continued to further ensure one usage of the trans amp will purchase were Reference response to Cross reference response W252.	slings.  loge pillow.  W210  W249.	
		Augustale August 1 - 1			· [	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LDING	(X3) DATE SI COMPLE	TED
		09G119	B. WIN	NG	i i	R <b>6/2007</b>
NAME OF P	ROVIDER OR SUPPLIER		**	STREET ADDRESS, CITY, STATE, ZIP CO 4515 EDSON PLACE, NE WASHINGTON, DC 20019	IDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	**************************************	I SHOULD BE	(X5) COMPLETION DATE
{W 210}	failed to show evide there was no transi wheelchair or in he QMRP acknowledge sling nor the wedge meet Client #2's as 3. Cross-refer to V ensure that Client # Occupational There 4. Cross-refer to V ensure that all staff implement Client # (hand-over-hand) to 5. Cross-refer to V ensure accurate do Client #2's behavior physical therapy ob 483,440(c)(3) INDI Within 30 days after interdisciplinary teal assessments or reasons when the control of the control	observation of the client's bed ence of a wedge pillow and fer sling in the client's redroom. At that time, the ged that neither the transfer e pillow had been purchased to sessed needs.  V210. The QMRP falled to received an updated apy assessment, timely.  V249. The QMRP falled to were trained to effectively 2's spout cup raining objective.  V252. The QMRP falled to recumentation of Client #1's and ral incidents and Client #3's ejectives.	{W 1:	10) W210 This Standard will as evidenced by:	ise met	
	This STANDARD i Based on observati review, the facility fa assessments had bafter admission by	the interdisciplinary team for in the sample. (Client #4)		applicated Occupational Assessment for chem	Johann L Therapy J #4,	12.2207 ongoing
ORM CMS-25	67(02-99) Previous Versions		2,	Facility ID: 09G119 If (	continuation sheet	Page 13 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Wish LTAILS O	A SOMEOUNI		B. WING _		R 11/16/2007
	ROVIDER OR SUPPLIER	09G119	l ere	REET ADDRESS, CITY, STATE, ZIP GODE	11/10/2007
IDI	KOVIDER OR SOFFLIER		4	515 EDSON PLACE, NE VASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF TH	OLD BE COMPLETION
{W 210}	Continued From pa	ge 13	{W 210}	·	
(W 249)	Qualified Mental Re (QMRP) revealed to a current Occupation. The most recent as September 26, 200 483.440(d)(1) PRO As soon as the interfermulated a client each client must retreatment program interventions and sand frequency to si	2007, interview with the etardation Professional hat Client #4 remained without onal Therapy assessment. Issessment was dated 6. GRAM IMPLEMENTIATION relisciplinary team has individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the din the individual program	{W 249}	W249 This Standard will be as evidenced by:	met
	Based on observative review, the facility fas outlined in the Ir (IPPs), for one of the (Client #2)  The finding include On November 14, 2 person was observed inner. After spoor of food, the staff too 'dropped' a drop or mouth, before resurrepeated the processmeal. At no time wor encourage the client in the factor of the staff too include the processmeal of the processmeal of the processmeal of the client in the staff too include the processmeal of the processmeal of the client in the staff too include the processmeal of the processmeal of the client in the staff too include the staff too include the processmeal of the processmeal o	s not met as evidenced by: on, interview and record ailed to implement programs idividual Program Plans ie six clients in the sample.  2007, a direct support staff ed feeding Client #2 her hing approximately 5 spoonfuls bik the client's spout cup and two of water into the client's ming with the feeding. She as again and throughout the as the staff observed to offer ient to place her hand on the ember 15, 2007, at 10:12 AM,		omen/nurse will continue monitor mealtimes, and provide direction and as needed, to ensure a compliance with this	foodback
OBM CM9-25	67(02-99) Previous Versions	Obsolete Event ID: DWO41	2 For	cility ID: 09G119 If contin	uation sheet Page 14 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M			(X3) DATE SU COMPLE	TED
		09G119	B. Wil	1Ġ			₹ 6/200 <b>7</b>
NAME OF P	ROVIDER OR SUPPLIER		•	4	EET ADDRESS, CITY, STATE, ZIP GODE 515 EDSON PLACE, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{W 249}	Client #2 to "participmouth to drink whe assistance" Staff	s IPP revealed a program for pate in bringing her dup to her n given hand over hand were not observed rogram as written during	{W 2	49}			
{W 252}	483.440(e)(1) PRO Data relative to acc specified in client in	GRAM DOCUMENTATION omplishment of the criteria dividual program plan documented in measurable	{W 2	52}	This Standard will be as evidenced by:	met	
	Based on observati verification, the faci was reflective of clie	s not met as evidended by: on, staff interview and record lity failed to collect data that ent's performance, for three of sample. (Clients #1, #3 and		(1)	amed will provide addition the staff training in the area and provide onep	ing	12:13:07 ongo:19
	AM, Client #1 was of inappropriate behave She screamed and with her hand. Clie mealtime protocol to support staff intervent immediately call the living room area clients. On November 3:45 PM, review of plan (BSP), dated of "screaming" and "rewere both targeted.	4, '2007, at approximately 7:00	- #10		to ensure that data col 15 a courate and reflect individual performance to \$3.00 to reference respondence \$1.	lection ts	- -

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	- }' '	JETIPLE CONSTRU	UCTION	(X3) DATE S COMPLI	
		09G119	A. BUIL B, WIN				R <b>6/2007</b>
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		4515 EDSON 5	S, CITY, STATE, ZIP PLACE, NE DN, DC 20019	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF C I CORRECTIVE ACTI REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{W 252}	sheets a few minute that staff had not do incident in her reconsidered. On November 1 was observed in the karaoke activities with Qualified Mental Responsive of the purpose of the purpos	w of Client #1's behavior data as later, however, revealed ocumented the behavioral rd:  4, 2007, at 4:55 PM, Client #4 a front foyer engaged in with direct support staff and the etardation Professional cimately 5:00 PM, the QMRP bet puzzle board to him, twice raile complied with the QMRP's phis hands away from his trely 5:30 PM, Client #4 was at foyer with a direct support dient was stimulating/himself ital area. The staff person move his hand away, and he	{W 25	52}			
		iciency. See Federal dated October 5, 2007 -					
	November 16, 2007 program objective v tolerate stretching to	e QMRP at 4:10 PM on indicated that Client #3 had an which stated that he "will his lower extremities daily stretch for 6 months." Further			· · · · · · · · · · · · · · · · · · ·		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SI COMPLE	
AND FLAN C	FORRECTION	IDENTIFICATION OF THE PROPERTY	A. BUILDING		,	₹
•		09G119	B. WING		1	6/2007
NAME OF P	ROVIDER OR SUPPLIER		45	EET ADDRESS, CITY, STATE. ZIP CODE 15 EDSON PLACE, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
{W 252}	objective revealed exercises should be session and that the performed of each documented. Addinstructions revealed implemented daily.  Documentation refliginglemented daily number of repetition documented only of data for November times a week and the performed was not evidence data was terms.  4. Interview with the 2007 at 4:07 PM reprogram goal to implemented the side of his bed day." Program data the program was in three days a week. 2007 reflected the twice daily on November 5, 2007, indicated that the frimplementation was changed from three	ctions for completing the that four different stretching a attempted during each e number of repetitions exercise should be tionally, the program should be and documented daily.  ected that the objective was in October 2007; however the ins performed was in October 7, 2007. Program 2007 was collected three the number of repetitions documented. There was no collected in measurable  the QMRP on November 16, wealed that Client #3 had a prove his static sitting balance ented twice daily. Review of led that the client "will sit on for two minutes threat times a a for October 2007 indicated in plemented once a day on Program data for November or orgam was implemented in plemented in the QMRP equency of the program is recommended to be a times a day to two times a	{W 252}			
·: .	measurable terms.	evidence data was obliected in	, =	ene parti e promini e e		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIÉR/CLIA IDENTIFICATION NUMBER:	'	JETIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		•	A. BUIL B. WIN		R		
		09G119	5, 14114	<u> </u>	11/16/2007		
NAME OF P	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP GODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	(D PREFI) TAG		OULD BE COMPLETION		
{W 252}	mobility. The object maximum assistan 5 repetitions 2 time Instructions reflected collected two times revealed that data value 13/31 days in Octol 2007 data revealed day every other day data was collected the client's perform 483.440(f)(3)(ii) PR CHANGE  The committee sho are conducted only	ctive "will roll in bed with ce from staff using bedrails for s a day at 100 % accuracy." ed that data should be a day. Record verification was collected once aday on ber 2007. Review of November data was collected once a factor that was no evidence the as recommended to monitor ance in the objective. COGRAM MONITORING & suld insure that these programs with the written informed it, parents (if the client is a	{W 26		il be i by:		
:	Based on observation review the facility facincorporate restriction behavior modification written informed co			Reference response to OMRP will obtain info consent will be obtain	rmed ongoing		
{W 436}	consent for the use Support Plan, which restrictive measure	ence of written informed of Client #4's Behavior incorporated the use of s. [See W124]	<b>(W</b> 43	6) W436			
		nish, maintain in good repair, use and to make informed					

the right brake repaired. The PT conducted a comprehensive assessment on April 20, 2007 and recommended the following repairs:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICALD SERVICES

STATEMENT OF DEFICI AND PLAN OF CORRECT			VSUPPLIER/CLIA ATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SU COMPLE	
			09G119	B. WIN				⋜ 6/2007
NAME OF PROVIDER O	R SUPPLIER		:		45	EET ADDRESS, CITY, STATE, ZIP CODE 515 EDSON PLACE, NE (ASHINGTON, DC 20019		
PREFIX (EAC	H DEFICIENCY	TEMENT OF DE MUST BE PREC SC IDENTIFYING		ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
a) Seat I b) Chest c) Relead d) Right e) No and The PT wheelch chair cot a physical 2007 who seating significant seating seati	se tabs on brake dam tit tippers recommend air and to util be obtained therapy a cich recommend asystem. A commend of the recommend of the rec	aligned se and ineffer armrest damaged ded to repair se it as a bained. Record assessment in the CMRF for the new indor, however was no ed in a fully control on the it was to frubber were was no ed in a fully control on the it was to frubber were was no ed in a fully control on the interved on the int	the old ckup until a new review revealed dated April 24, w wheelchair and g 719A dated July h custom seating rd. At the time of he release tables damaged. indicated that wheelchair was er the vendor had vidence Client #1 elchair to ensure sperable good w wheelchair.  30 AM, Client #1's eent and the tires e missing). A left side of the v with the QMRP ximately 9:38 AM ested for the tive equipment of as follows: and new chairs is	{W 4:		OMEP will coordinate as exaft training as no		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 11/27/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		l` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLANC	O CONNECTION	1000	[	A. BUILDIN	IG		R	
		1	09G119	B. WING _			6/2007	
NAME OF F	ROVIDER OR SUPPLIER			4	REET ADORESS, CITY, STATE, ZIP CODE 1515 EDSON PLACE, NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	TEMENT OF DE MUST BE PRE SC IDENTIFYING	JEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 436}	Continued From pa c) New tires need d) Brakes not eng e) Recommendati Wheels too old; ch A wheelchair asses revealed a need for repair, and repair or review revealed a s 2007 for repairs on replacement of tires wheelchair assess also documented w brakes did not lock 8/10/07 for replace was observed in the wheelchair vendor's 2007 revealed a bro wheels (both), no h The broken items or recommended to be the assessment hor the wheelchair coul review revealed an therapy assessment damaged her most using her old custor Follow-up on the wh recommended.  The QMRP stated to received wheelchair review of Client #1's plan revealed a rece wheelchair be main no evidence, howev timely repairs to her they were maintained	ed for old chaging proper on for seat rair needs resting gned 719A the seating and brake hent dated forn wheels/foroperly. A nent of tires client's receplaced. Wever that the chair verelaced which state recent wheels in molded wheelchair repart of the chair of the c	epairs for tear.  placement  June 30, 2007 ment, brake system. Record dated July 15, system, repair. A second ugust 10, 2007 ires and that the 719A dated and brake repair ord. The it on August 23, a, damaged rear chest harness.  Vere It was noted on it e manufacture of ited. Record 007 physical ied the client ichair and was ineelchair. airs was  Is most recently the facility. The agement care in that her times. There was it #1 received s) to ensure that	{W 436}				
•	•							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DW0412

Facility ID: 09G119

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/27/2007 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
			1:				}	R
	:	j	09G119	B. WIN	1G _		11/1	6/2007
NAME OF F	ROVIDER OR SUPPLIER		:	<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	<del>/</del>	
	NOTICE CONTRACTOR	•	:			515 EDSON PLACE, NE		
IDI		į				VASHINGTON, DC 20019		
	CLUMPA DV OTA	TENENT OF DE	FINENCIES	1 15		PROVIDER'S PLAN OF CORREC	TION.	(VE)
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		j	-	, <u>.</u> ,		DEFICIENCY)		
{W 436}	Continued From pa	ge 21		{W 4	36}	W436, continued		
	2. The facility failed	! <del>-</del>	he recommended			V1 136) Billians		
	knee braces for Clic							
	,		,			amon in Cillana was w	wh	
	a. Interview with the	Qualified N	lental Retardation	ļ		amer will follow-up w	, IT V 1	·
	Professional (QMR)			1		Physical Therapist as it to ensue that all Ad	meded	
	4:18 PM indicated t	1	: 1 '	i		Pringsical all and	م بلم	j
	appointment to be a					to ensue that an Ho	aprive	
	recommended knee	1	: 1			accompand back	n w	ļ
	hospital on October			İ		equipment needs	urc	i
	with the QMRP reve provided pictures of					met.		
	which a selection w					(1,00,1		12.18.07
	company able to pre							121201
	review of the physic		·					
	April 24, 2007 revea							
	recommended at th			!		No a barrage Occober 1	11-7	İ
	evidence the knee I	prace had of	tained for the			Knee braces for chent		)*
	client.	ļ '	:			will be ordered as reco	างโกเลตองพเ	1, 1
		l		i		1000	THE PERSON NAMED IN THE PE	1
	b. On November 1							
	was observed seate	1 9	1 1					
	review of her physic					amed will maintain docu	ıməytəti	M
	June 16, 2007 rever purchase knee brace	1	. 1					,
	extension range of i					to reflect actions taken	^	
	Interview with direct							
	at approximately 2:5					toward securing al	J	
	did not have knee b							<b>,</b>
	QMRP on November	r 15, 2007 å	at 3:18 PM		ļ	recommended egu	p ment	
	indicated that Client					equipment repairs	' /	
	There was no evide				- 1	egyymerci repuirs	1	
	recommendation for	1	s for Client #7					
	had been addressed	<b>31.</b>	į į			Active Treatment Specialist	liiw -	i i
ļ	3. Cross-refer to W	1500 The	facility failed to			notive martinery specialist	-	
	make available and					continue to document status/condition of		
	transfer slings and/o					chatus/randition of		
	in bed.	l moage to	-		ļ	wheelchair on a week	In pacie	. [
•						MNEETCHAIL 21. 1. MOOL	اردسارا	
		1					,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DW0412

Facility ID: 09G119

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPI IDENTIFICATION N		A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED R 11/16/2007	
NAME OF P	ROVIDER OR SUPPLIER		4515 EDS	ORESS, CITY, ON PLACE TON, DC			
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	A follow-up survey we November 14, 2007 Residents #2 and #1 from the five residents to the sample.  In addition, focused follow-up to the Octofollows:  Resident #1's meanintake, repositioning needs; Resident #3's active and adaptive equipments.  The findings of this subservations, intervial administrative staff in program serving three	vas conducted from through November 5 were randomly so the originally sampled and #7 were the reviews were conducted from protocol, nutrement, physical thereselves with direct survey were based ews with direct survey of the sampled	er 16, 2007. elected led in nen added ducted in y, as ritional ipment cal therapy time apy on oport and a day residents,	{1 000}			
{  047}	and the review of recreports and administ reports and administ 3502.5 MEAL SERV Each GHMRP shall that meals, which are GHMRP, are suited tresidents as indicate Habilitation Plan.  This Statute is not make the served on observation verification, the facilitiserved away from the	rative records.  ICE / DINING ARE  pe responsible for e served away fronto the dietary need d in the Individual  net as evidenced b n, staff interview are ty failed to ensure	EAS ensuring n the s of  y: nd record that meals	{I 047}	1047 3502.5 This Statute will be as evidenced by:	met	
ilth Regulation	tion Administration  WU MUNCH	R/SUPPLIER REPRESEI			Ses		X8) DATE 2:6:07

DWO412

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STATE FORM

If continuation sheet 1 of 14

	rement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 11/16/2007	
NAME OF P	ROVIDER OR SUPPLIER	- 555.19	· · · · · · · · · · · · · · · · · · ·	DRESS, CITY.	STATE, ZIP CODE	
IDI		177	4515 EDS WASHING	ON PLACE, STON, DC 2	NE 0019	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{1 047}	Continued From pa	ge 1		{  047}		
{1 047}	Continued From paresidents' dietary neresidents in the same. The findings include On November 14, 2 observed at her day AM. Although the Oprofessional (QMRI this day program or deficiencies were iddeficiencies were iddeficienc	eds, for one of ple. (Resident program, becausified Ment october 23 entified, as for a holding here is a holding here. The holding here is a holding here is a holding here is a holding here.	at #5 was ginning at 10:36 tal Retardation tented a visit to 2007, continued allows:  The day program g in the cafeteria plate. He was born the "serving high sided plate, to time during ate her lunch the a plate guard the was tely 12:05 PM, and that she was aff at the day "eats by herself" lied. A few coordinator also ntly. At 11:52 ating without ing her food not provide her ow her pace. at day in the	{1 047}	Reference response Federal Deficiency Ri W120 and W159.	to 12.20.07 ongoing
	residence, the Directechnique by which for Resident #5 to e a second spoon to p	staff provide v at more slowly	verbal prompting y. Staff also use			
Health Regula	ation Administration					<del></del>
STATE FORM			e	1889 D	WO412	If continuation sheet 2 of 14

DWO412

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G119		(X2) MULT A. BUILDIN B. WING _		(X3) DATE SURVEY COMPLETED  R 11/16/2007	
NAME OF P	ROVIDER OR SUPPLIER	, Hen	STREET ADDR	RESS, CITY,	STATE, ZIP CODE		
ומו			4515 EDSO WASHINGT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
{I 047}	towards the back at meant that the reside the spoon ("1/2 a te The QMRP describe an interview that be that this was the on without upsetting the QMRP acknowledge the information with the should be noted that the should be noted that the should be noted the on November 14, 20 November 15, 2007 she had not observe funch meal during he the day program. Shad not returned to verify that staff were	nd side of her plate. Lent scooped less for aspoon instead of he ed the same technique an at 4:00 PM. Show way staff could into the resident. At 4:33 Fed that she had not yet.	Doing os od into eaping"). ue during e stated ervene PM, the yet shared lee QMRP aled that ving her visit to at she ce then to ing the	(1 047)	_		
{I 056}	preparation and sen care of equipment, a to maintain sanitary  This Statute is not a Based on interview a staff training records ensure that a certific	train staff in the storying of food, the clear and food preparation conditions at all time net as evidenced by and review of persons, the GHMRP failed	age, in order es. innel and to available	I 056}	(1056) 3502.14 This Statute will I met as evidenced by	oe ov:	
L	every meal.  The finding includes	     007, at approximatel	y 10:30				

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If continuation sheet 3 of 14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE IDENTIFIC	R/SUPPLIE ATION NUI		(X2) MULT A. BUILDIN B. WING		(X3) DATE S COMPLE	
		09G11	9				11/1	6/2007
NAME OF F	ROVIDER OR SUPPLIER	: S :			,	STATE, ZIP CODE		
101					ON PLACE TON, DC 2			<u> </u>
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PRE	ÇEDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BË	(X5) COMPLETE DATE
{I 056}	continued From parabout which staff has certifications. She is the corporate office information that was day, at approximate evidence that the Goertified food handle preparation and serindividual with a cur certification was the records indicated the	ad current for sought document from the sent food has been the sent food food food food food food food foo	mentation the persective office revealed that the persection of th	n from onnel later that I no a eal he only ersonnel	(I 056)	Direct Support staff wi be scheduled to atter next food handbers certification. Training Manager wi continue to monitor track staff complia	id the	12:18:07 ongoing
{I 206}	staff were without of certification.  3509.6 PERSONNE Each employee, prisannually thereafter, certification that a high performed and that would allow him or aduties.	urrent food ) EL POLICIE or to employ shall provid ealth invent the employe her to perfor	ment and er's ment and e a physiory has been the re	d cian ' s een alth status quired	{I 206}	and provide recording needed.  (1206)  3509.6  This Statute will met as evidenced	be by:	
	This Statute is not in Based on interviews facility failed to show certification/inventor.  The findings include Review of personne during the revisit, or approximately 2:00 a current health certifollowing individuals  1 of the 12 direct settion Administration.	and record v evidence of y for all per : information November PM, reveale ification/invecting wit	review, for a curre sonnel. n made a 15, 2007 d no evid entory for h the res	the ant health wailable 7, at lence of the idents:	~ :	Current health certifical will be obtained for o hune, and the so worker.	NL	12:18:07

STATE FORM

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If continuation sheet 4 of 14-

	T OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA ATION NUMBER:	A. BUILON	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R
		09311	<u> </u>	DOESS CITY	STATE ZID CODE	11/16/2007
I D I	PROVIDER OR SUPPLIER	1	4515 EDS	ON PLACE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
{  206} {  206}	Continued From page - 1 of the 10 nurses - the social worker 3514.2 RESIDENT	(N1)	· · · · · · · · · · · · · · · · · · ·	{I 206} {I 291}	(1206) Human Resources and A Assistant will continu monitor on a regular request information ( (1291)	_
	Each record shall be signed by each indiv. This Statute is not represented to up indicated, for two of sample. (Residents) The findings include	net as evide and record of date residen the six resid #1 and #4)	akes an entry. nced by: eview, the t records as		3514.2 Resident Re This Statute will met as evidenced	be by =
	1. Nursing supervis to ensure accuracy or records, as follows:  On November 15, 20 PM, review of Resid Notes revealed that AM, a nurse wrote the on right hand. No panormal salinePCP review of the Staff D Resident #4's record was documented on was no daily progress November 10, 2007, was asked about the she stated that she wany "pink areas" discidid, however, state the afful shot on November 10 in the she stated that she wany "pink areas" discidid, however, state the she she shot on November 10 in the she stated that she wany "pink areas" discidid, however, state the she she shot on November 10 in the she she she she she she she she she s	of Resident #  207, at approper #4's Nurse following in noted. Are made aware ally Progress revealed no November \$1.08 PM nurse's proyered on Resider 9, 2007.	ximately 12:30 sing Progress r 10, 2007, 8:30 sing progress r 10, 2007, 8:30 sing progress r 10, 2007, 8:30 sing progress in thing unusual progress note and ly unaware of esident #4. She and had received		Reference responsi Federal deficiency will and W252	report: 12:13:07 ongoing
	Initially, this was bein tion Administration I	1	ir it were an	89 DI	WQ412	If continuation sheet 5 of 14

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If continuation sheet 5 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SI COMPLE F 11/1	TED		
NAME OF F	ROVIDER OR SUPPLIER			STREET AD	DRESS, CITY,	STATE, ZIP CODE		•	
IDI		4.1VA			SON PLACE, NE GTON, DC 20019				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PREC	EDED BY	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{  291}	Continued From painjury of unknown or interview with the List 1:16 PM, reveale seen the pink area shoulder," where the administered. Furthhad not been aware received a flu shot of shot, however, had same Nursing Programmenurse indicated that hand" instead of incommon error in cell However, the Direct the telephone that too far apart to get of Resident #4's medic evidence that super reviewed Resident accuracy.  2. Nursing staff fail #4's HMCP, to reflephysical therapy protreatment for pain, are a. On November 19 #4's Health Manage dated September 20 for pain due to DJD stands for degeneral HMCP indicated the resident range of monitor for signs of resident's updated for dated October 5, 20 therapist and interdict interdict in the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident's updated for the sident range of monitor for signs of resident range of monito	rigin. Howeld had that the number interview that the resemble on the day been documented interview or of Nursing the error of icating the urtain immigator of Nursing the hand and confused." Fall chart faile visory nursing the hand and confused." Fall chart faile visory nursing the hand and confused." Fall chart faile visory nursing the hand and confused." Fall chart faile visory nursing the hand and confused." Fall chart faile visory nursing the hand and confused to update of a change of the programs and the fall chart faile visory nursing the hand and confused to update of a change of the programs and the fall chart faile visory nursing the programs and the fall chart faile visory nursing the programs and the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the fall chart faile visory nursing the failed visory nursing the fall chart failed visory nursing the fall chart failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed visory nursing the failed vi	made the reserve to provice that his police to show that his police to show the reserve to provice that his that his police that his police to provice that his police to provice that his police that his police to provice that his police to provide that his police	the entry, indeed ear the d that he id he flu in the ember 9, he day right in was a ulations, ated over arm "are eview of ow had to ensure Resident MCP), otential out, DJD he de the es and to ew of the an (ISP), is physical	{  291}				
ealth Regul	ation Administration	<u> </u>				<u>.</u>	<u> </u>		

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If continuation sheet 6 of 14

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE	R/SUPPLIER/C ATION NUMBI		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMP	LETEO
		09G11	i ·		B. WING		- 441	R 46/2007
NAMEOF	ROVIDER OR SUPPLIER	1 5		TREET ADD	RESS CITY	, STATE, ZIP CODE		16/2007
NAME OF F	KOVIDER OR SUFFLIER		1					
ופו	·			IS15 EDSC VASHINGT				
(X4) ID		TEMENT OF DE		.,	ID.	PROVIDER'S PLAN (		(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L				PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	DATE
{I 291}	Continued From pa	ge 6		-	(1 291)			
	the programs and the	ne resident n	ow was to	ŀ				1
	ambulate around th						•	
	minutes with staff in	1	1 :				•	
	The HMCP had not		d to reflec	t the				
	new ISP objectives.	1						1
		l						
`	b. In addition, the H			ie use				
	of medication for tre			.				
	Resident #4's physic							
	June 1, 2007 includ					<u> </u>		
1	dated May 1, 2007 twas ordered as nee							
	greater than 100 de							İ
	the resident was eva							
	experiencing pain a							1.
	and foot. The ER d							
	primary diagnosis "a	rthritis - deg	enerátive."	The		-	•	
	primary care physici							
	October 4, 2007 did							
	however, his SOAP							
	included "P: Tylenol			tober				
	13, 2007 SOAP note							
	frequency/ paramete							Ì
	Tylenol. The most r			S		•		
	issued/ printed by th September 1, 2007.			1				
	Further review of the			ord				
	failed to clarify wheth	her the Octo	her 13 200	17				}
	SOAP note was a co					,		
	as needed (PRN) ba							
	a change to daily/ ro							
1	3. Facility staff failed	d to documer	nt in Resid	ent				
	#1's and #4's record							i
	behavioral data that	was reflectiv		nts'				[
İ	performance, as folk	bws:				!		
,	a. On November 14	, 2007, at ab	proximate!	v 7:00		· -		
· 1	AM, Resident #1 wa	s observed d	isplavina	,		1		ļ <b>!</b>
	nappropriate behavi			∍.				
	tion Administration		· · · · · · · · · · · · · · · · · · ·				<del> </del>	
TATE FORM		1		6899	-	)WO412	if nontinuoi	on sheet 7 of 14

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If continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	BER. A. E	) MULTIPLE CONSTR BUILDING WING	UCTION		
NAME OF PROVIDER OR SUPPLIER	<del></del>	STREET ADDRESS.	CITY, STATE, ZIP CO	DDE		10,200,
IDI		4515 EDSON PL WASHINGTON,	LACE, NE			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL PRE	FIX (EAC	OVIDER'S PLAN OF COR I CORRECTIVE ACTION REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Resident #6 with he over a mealtime property staff resident did not immediate wheeled her into the from the other resident's behavior. October 5, 2007, resident's behavior. October 5, 2007, resident's behavior october 5, 2007, resident's personal targeted maladaptive instructed staff to do Review of Resident few minutes later, he had not documented incident in her record.  b. On November 14 #4 was observed in karaoke activities with Qualified Mental Resident and alphate He rejected the puzz face a few times. He request that he keep face. At approximate was observed in the support staff person sughand away, and he of 2007, at approximate Resident #4's BSP, revealed that "face seen masturbation" were behaviors. The BSP every occurrence.	tried to grab or strike r hand. Resident #1 lotocol that was on the intervened and when nediately calm down, to living room area and ents. On November 1 tely 3:45 PM, review of support plan (BSP), divealed that "screaming others" were bother behaviors. The BSI occument every occurred the observed behavior. The BSI occument every occurred the observed behavior.  1, 2007, at 4:55 PM, Resident the front foyer engaged the front foyer engaged the direct support staff tardation Professional imately 5:00 PM, the Control of the complied with the Quantity in the general professional front foyer with a direct resident was nanually in his genital agested that he move complied. On November 19, 3:49 PM, review of dated August 19, 200	table. the they away 16, f the ated g" and cence. eets a staff oral esident ed in and the QMRP n, twice. his MRP's his t#4 ct area. his cer 16, 7, otive cument				
lealth Regulation Administration TATE FORM		6899	DWO412		16	on sheet 8 of-14

If continuation sheet 8 of-14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDEN/SUPPLI IDENTIFICATION NO 09G119		(X2) MULT A BUILDII B. WING	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED R 11/16/2007	
NAME OF P	ROVIDER OR SUPPLIER		4515 EDS	DRESS, CITY. SON PLACE STON, DC 2			•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC! MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	PLETE
{  291}	Continued From particles to the observed behave. This is a repeat defined Deficiency report day W252.	hat staff had not do ioral incident in his ciency. See Federa	record. al	{i 291}			
l 401	3520.3 PROFESSIO PROVISIONS  Professional services and evaluation, includevelopmental level services, and services deterioration or further resident.	s shall include both ding identification of and needs treath es designed to prev	i diagnosis of nent vent	I <b>4</b> 01	1401 3520.3		
	This Statute is not r Based on staff inten- facility failed to ensu- accordance with the residents in the sam	iew and record revices needs of one of the ple. (Resident #4)	iew, the in		This Statute will met as evidenced	loe loy:	,
	The findings include  1. Nursing supervise effective monitoring area, for signs of poside effects of the flu	ors failed to provide of Resident #4's flu tential adverse read	shot		Cross reference resp to 1291,	ionse 12:18: ongoi	
-	Cross-refer to I291. approximately 12:30 Nursing Progress No November 10, 2007, following: "slight pink noted. Area cleaned made aware." At 1:0 that the resident had November 9, 2007.	PM, review of Resingles revealed that on 8:30 AM, a nurse warea on right hand with normal saline.  8 PM, the "day nurse warea."	dent #4's n vrote the . No pain PCP se" stated	<u>-</u>			
ealth Regula TATE FORM	tion Administration			999 D/	NO412	If continuation sheet 9	9 of 14

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	IMBER.	A. BUILDIN B. WING		_ COMPL	(X3) DATE SURVEY COMPLETED R 11/16/2007	
NAME OF P	ROVIDER OR SUPPLIER	11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	4515 EDSO WASHING	ON PLACE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRESEDED BY C IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	Telephone interview the entry, at 1:16 PM seen the pink area of shoulder." Further in not been aware that flu shot on the day that been document Progress Notes, on  2. Nursing staff faile #4's HMCP, to reflet physical therapy professed therapy professed therapy professed the Progress Notes, on  7. Nursing staff faile #4's HMCP, to reflet physical therapy professed therapy professed the provide the resident and to monitor for significant to ambulate around 3 minutes with staff been updated to refl In addition, the HMC for Tylenol 650 MG in the beginning of Oct 3:30 PM, interviews and the Director of Nupport staff who we implementing the professed in the professe	with the LPN who In the revealed that the inthe "upper arm, interview revealed the the resident had reveroe. The flu shot ed in the same Nurse to a change in the regrams.  Oo7, at Review of Regrams.  Oo7, at Review of Regrams.  Oo7, at Review of Regrams.  Oo7, at Review of Regrams.  Oo7, at Review of Regrams.  Indicated that staff range of motion excepts of pain. However, at a line in the resident the home and dancinstead. The HMCF ect the new ISP object the new ISP object the review of Resident the fluid to reflect the armbulate or to dan ober 2007. At appropriate the programs in the personsible for ograms had not bee	nurse had hear the hat he had ceived a however, sing  Resident MCP), was not pain due were to ercises were to ercises when that his earn had now was e for up to had not ectives. e order herwise).  Int #4's dithat he ice since oximately in urse timetal had not ectives.	i 401				
lealth Regula TATE FORM	ition Administration 1	-	689	• DI	WO412	If continuation	n sheet 10 of 14	

If continuation sheet 10 of 14

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	IDENT	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 11/16/2007
NAME OF PROVIDER OR SU	PPLIER	4515 EDS	ORESS, CITY, ON PLACE TON, DC 2		
PREFIX (EACH DE	ARY STATEMENT OF FICIENCY MUST BE P RY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
and assistant the resident  This Statute Based on observer, the fatraining and residents' Incofe the six residents' Incofe the six residents with the findings  1. Cross-reficitations W1 to monitor to implemented protocols, as 2. The facilities sheets were recommended a. Resident wheelchair of the review of assessment, 16, 2007 at 2 recommended and observative revealed the bedroom. In indicated that underneath tiles.	P shall provide hoce to residents in sort met as exservation, interviacility failed to provide acility failed acid for Resident #2's a updated on Octory failed to ensure purchased and/or purchased and/or Resident #3's provide acid for Resident #3's provide	nabilitation, training in accordance with bilitation Plan.  idenced by: ew and record ovide habilitation, cordance with Plans (ISPs), for five in the GHMRP failed programs in transfer in used as #3, #7 and #2.  seated in his 2007 at 8:52 AM. Thysical therapy (PT) 2007, on November a transfer sling was in direct care staff in 16, 2007 3:00 PM in the resident 's DMRP at 3:15 PM g should be placed in his sin the fis in his	1422	Cross reference restored Deficient Peport WIZO and	ponses nay ongoing wisq,
home from hi	s day program a 5, 2007 without h	t 3 40 PM on is transfer sling in	. <u> </u>	WO412 -	If continuation sheet 11 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION 09G119		(X2) MULTA. BUILDI			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE	•	
IDI		4 : : : : : : : : : : : : : : : : : : :	4515 EDS WASHING	ON PLACE TON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
1 422	Continued From pa	ge 11		I <b>4</b> 22			
	his wheelchair.						
	h On November 1	1 2007 ot 8*20 AM	Rocidont				ļ
	b. On November 14 #7 was observed so						
	review of her PT as						
	2007, revealed a re		- 1				
	transfer sling. Obs	ervation and interv	iew with				
	staff on November						
	2:50 PM revealed ti				ì		
	resident's bedroom 2:55 PM revealed ti						
	with the resident to						
	with the leadent to		'9 <sup>,</sup>		1		
	c. On November 14	4, 2007, at 6,43 PN	1, the				
	QMRP and a certific	ed nursing assistar	nt were				
	observed transferring				1	•	
,	wheelchair into a re						
ľ	had some difficulty				1		
	records indicated w process. On Nover						
	the QMRP confirme			,	•		
	difficulties in transfe						
	further indicated that						
	participating in the t						
	degree. At 7:02 PM						
}	assessment, dated recommendation to						
	and a "wedge to use						
	bed." At 7:11 PM, o				·		
	bed failed to show e						
į	and there was no tra				†		
	wheelchair or in her						
1	QMRP acknowledge sling nor the wedge						
	meet Resident #2's		archased to				
	·	i			•	•	
· .	3. The GHMRP fail					<u>-</u>	
-	outlined in Resident		ogram [				
ĺ	Plans (IPPs); as follo	ows:		l			
-111 5							
alth Regula ATE FORM	ition Administration		689	· -	1100.440		
AIE FURN	n	1 !	681	·• D	WO412	If continuation	n sheet 12 of 1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		<del></del>	A. BUILD B. WING		•	
NAME OF PROVIDER OR SUPPLIER		i		Y, STATE, ZIP CODE		_
IDI			OSON PLAC NGTON, DC			
(X4) ID SUMMARY ST/ PREFIX (EACH DEFICIENC' TAG REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
On November 14, 2 person was observed inner. After spoor of food, the staff to and 'dropped' a droped and 'dropped' a droped and 'dropped' a droped and 'dropped' a droped and throughout the mean observed to offer or place her hand on the 15, 2007, at 10:12 IPP revealed a program at the 14, 2007, at 10:12 IPP revealed a program as written 14, 2007.	ed feeding Reling approximate the resider por two of welfore resuming the the process of the two to the spout cup. The spout cup to the spout cup to the two the two the two the two the two two two two two two two two two two	esident #2 her nately 5 spoonful of spoonf				
adaptive equipment interdisciplinary teal maintained for three in the facility. (Clier The findings include a. The facility failed Client #1's and #3's b. The facility failed knee braces for Clief knee braces for Clief (I 500) 3523.1 RESIDENT'S Each GHMRP resid that the rights of resprotected in accordance chapter, and other a laws.	identified as n were furnise of of the six its #1, #3, and to ensure time wheelchairs.  to furnish the nts #3 and #3  RIGHTS  ence directoridents are obince with D.C.	needed by the hed and clients residing d #7)  nely repair of e recommended 7.  shall ensure served and Law 2-137, this	{I 500}	(1500) 3523.1 Resid	ents Rights	
TATE FORM		•	8899 F	DWO412	lf = = = 4!=4!	sheet 13 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119		(X2) MULT A. BU(LDII B. WING	TIPLE CONSTRUCTION  NG	•	
NAME OF PROVIDER OR SUPPLIER			:		STATE, ZIP CODE		
4515 EDSON PLACE, NE WASHINGTON, DC 20019							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ON SHOULD BE COMPL E APPROPRIATE DAT	
{I 500}	This Statute is not Based on observation review, the facility to habilitation services with identified needs in the sample. (Resident Helphane)  1. Cross-refer to Fe Citations W120 and to monitor to ensure implemented Reside protocols, as update  2. Cross-refer to I43 ensure that transfer repositioning were precommended for R  3. Cross-refer to Fe Citation W210. The Resident #4 receive Therapy assessment  4. Cross-refer to Fe Citation W249. The all staff were trained Resident #2's spout training objective.  5. Cross-refer to Fe Citation W436. The repair of Client #1's failed to furnish the refor Clients #3 and #7	met as evidence, interview as ensure the in and supports for five of the idents #1, #2, idents #1, #2, idents #2's and #2's and #2's and #3's wheels and period dan updated to effectively cup (hand-over deral Deficients facility failed to effectively cup (hand-over deral Deficients #3's wheels and #3's wheels ecommended	and record ight to receive in accordance in accordance in six residents in 3, #5 and #7)  ancy Report - GHMRP failed grams in the six residents in the six residents in the six residents in the six resident	{  500}	(1500) - continued.  This Statute will be as evidenced by:  (1) Cross reference in Report W120 and Percence in 1422,2  (2) Cross reference in response to federal Report W1210.  (4) Cross reference report w1210.  (4) Cross reference report w1210.  (5) Cross reference in Report W1249.  (6) Cross reference in Report W1249.	esponse ency 1 W159. esponse esponse t sponse ency	ongoing

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